THE LONDON CLINIC

Vascular request

PATIENT INFORMATION

indicates mandatory fields

*TLC unit no. (if known) L

*Title

*DOB dd/mm/yyyy)

*Surname

*Forename(s)

*Sex at birth M F

Gender:

IP OP DC

Room

*Referrer's full name and / or practice stamp

Payment method ☐ Insurance ☐ Embassy ☐ Self-Pay ☐ Sponsor

Payment provider

Member no.

Authorisation no.

Patient's tel no.

Patient's email

*Patient's address

Copy of reports to

CLINICAL INFORMATION

Infectious:	Yes ☐ No ☐
If yes, Barrier nursed:	Yes ☐ No ☐
Oxygen required:	Yes ☐ No ☐
Mode of transport:	Walking ☐ Wheelchair ☐ Bed ☐ Portable ☐
Date & time of appointment	

N.B. This form is a legal document – Referrer's Declaration

- The correct patient details have been provided.
- I have discussed the examination, including any intervention, with the patient / guardian.
- I have taken into account the possibility of pregnancy
- I have given sufficient clinical information for the request to be justified according to IR(ME)R 2017.
- I will ensure that the examination results are recorded in the patient's notes.

***Clinical indication for examination.** Please summarise relevant history, clinical findings, previous imaging and test results. Indicate the question that the examination should answer.

Examination requested	Right	Left	Bilat
Ankle pressures (ABPI)			B
Aortic duplex (fasting)	YES		
Arterial lower limb duplex (fasting)	R	L	B
Arterial upper limb duplex (fasting)	R	L	B
Carotid + vertebral duplex			B
Central / upper limb venous duplex	R	L	B
Exercise test - pre/post ABPI			B
False aneurysm	R	L	B
Lower limb graft surveillance/EVAR (fasting)	R	L	B
Medical legal vascular (extended)	R	L	B
Popliteal artery entrapment			B
Pre fistula/Fistula upper limb duplex	R	L	B
Venous lower limb duplex	R	L	B
Venous pre op marking	R	L	B

Referrer's signature _____ Date ____/____/____

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